

CENTERS FOR DISEASE CONTROL AND PREVENTION

Request for Antimalarial Drug Analysis

Requested by: ☐ Peace Corps ☐ State Dept. ☐ Military ☐ Other _____

Physician: _____ E-mail: _____ Phone: _____

Patient name: (last) _____ (first) _____ Sex: ☐ Male ☐ Female

DOB: _____ Probable region infection was acquired: (Country) _____

Treatment: ☐ Chloroquine ☐ Hydroxychloroquine ☐ Mefloquine ☐ Quinine ☐ Doxycycline

☐ Tetracycline ☐ Fansidar ☐ Malarone ☐ Fansidar ☐ Coartem ☐ Other _____

Dose (mg) _____ Date of last dose _____

Prophylaxis: ☐ Chloroquine ☐ Hydroxychloroquine ☐ Mefloquine ☐ Quinine ☐ Doxycycline

☐ Tetracycline ☐ Fansidar ☐ Malarone ☐ Fansidar ☐ Coartem ☐ Other _____

Dose (mg) _____ Date of last dose _____

Type of analysis requested: ☐ Blood levels ☐ Drug Quality

Drug requested for analysis: ☐ Chloroquine ☐ Hydroxychloroquine ☐ Mefloquine ☐ Quinine

☐ Atovaquone

Specimen type: ☐ Whole blood ☐ Plasma ☐ serum ☐ Tablet ☐ Injectable ☐ Suspension ☐ Syrup

Collection tube: ☐ EDTA ☐ Heparin ☐ Citrate ☐ Other _____

Date of collection: _____

Instructions for Submitting Specimens

Blood Specimens - Collect 1-2 ml into labeled (patient name and date of collection) tubes. Pack with "cool packs" and absorbent material to contain any leakage. Ship by overnight carrier to:

Attn: M. Green
US Centers for Disease Control and Prevention
1600 Clifton Rd. Building 23 Room 167
Atlanta, GA 30329

Antimalarial Drug

Collect 3 or more tablets or other dosage forms and send to address above.